APPLICATION FOR APPROVAL OF CONTINUING EDUCATION PROGRAMS FOR CHIROPRACTORS

State Form 50713 (12-01)

HEALTH PROFESSIONS BUREAU
402 West Washington Street, Room 041
Indianapolis, IN 46204

DATE RECEIVED / POSTMARKED	
APPROVAL DATE	
CONTINUING EDUCATION HOURS GRANTED	

SPONSORING CHIROPRACTIC COLLEGE OR ORGANIZATION

Name of sponsoring college or organization		
Address (*number and street, or Post Office box*)		
City	State	ZIP code
Telephone number	E-mail address	Website

PROGRAM COORDINATOR

Name of course coordinator		Title
Mailing address (*number and street, or Post Office box*)		
City	State	ZIP code
Telephone number	FAX number	E-mail address

PROGRAM TO BE OFFERED

Program title

Program Date(s)	**Location of Program (*City and State*)**
Total Number of Continuing Education Hours Requested	

CONTINUING EDUCATION HOURS REQUESTED FOR APPROVAL

Please break down your program in the proper categories with the number of continuing education hours requested.

CATEGORY	HOURS REQUESTED
DIAGNOSIS AND EXAM PROCEDURES	
PRINCIPLES OF PRACTICE	
PHYSICAL THERAPY / PHYSIOLOGICAL THERAPEUTICS	
NUTRITION	
ADJUSTIVE TECHNIQUE	
RADIOGRAPHIC TECHNIQUE / SAFETY	

(*Continued on the reverse side*)

CONTINUING EDUCATION HOURS REQUESTED FOR APPROVAL (*Continued*)

Please break down your program in the proper categories with the number of continuing education hours requested.

CATEGORY	HOURS REQUESTED
DIAGNOSTIC IMAGING INTERPRETATION	
BASIC SCIENCES	
RESEARCH TRENDS	
SCOPE OF PRACTICE	
RISK MANAGEMENT	
Insurance Reporting / Procedures	
Medical / Legal	
HIV Prevention / Education	
Boundaries Issues	
Public Health and Safety	
Documentation / Medical Records	
OTHER (*SPECIFY*):	
TOTAL NUMBER OF HOURS REQUESTED FOR APPROVAL	

PLEASE NOTE: The Indiana Board of Chiropractic Examiners has determined that courses in the areas of practice management, contact reflex analysis, acupuncture and philosophy are not acceptable for approval of continuing education hours.

NAME OF INSTRUCTOR(S)

Please list the names of instructor(s). Attach curriculum vitas or resumes.

VERIFICATION OF ATTENDANCE

Who will maintain adequate records of course participants and agree to provide participants with a record of attendance and to retain records of attendance by participants for four (4) years from the date of the program?

What is the method of certifying attendance?

ADDITIONAL INFORMATION REQUESTED

1. Have you enclosed a copy of the advertisement brochure and / or promotional materials, if used?	☐ Yes	☐ No	☐ NA
2. Have you submitted the following information with your application:			
a. Course syllabus or outline of the material covered in the course giving specific times of lectures.	☐ Yes	☐ No	
b. A brief summary of the program content	☐ Yes	☐ No	
c. Date(s) of the program	☐ Yes	☐ No	
d. Location(s) of the program	☐ Yes	☐ No	
e. The number of hours requested.	☐ Yes	☐ No	
3. Have you enclosed curriculum vitae and / or resumes of all instructors showing education and professional background?	☐ Yes	☐ No	
4. Have you read and reviewed 846 IAC 1-8 regarding the approval of continuing education programs for chiropractors?	☐ Yes	☐ No	

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)